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The Opioid Epidemic: What is a Child Psychiatrist to do?

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Background

The United States is currently in the midst of a public health crisis due to the opioid epidemic. A record number of individuals, 47,055, died of a drug overdose (OD) in 2014.¹ Although the drug poisoning death rate has been highest among 45 to 54 year olds an increase in mortality has also been seen in youth. Poisoning deaths among adolescents increased by 91% between 2000 and 2009 largely due to an increase in OD from prescription drugs.² All physicians, pediatric and adult, are needed to change the course of the opioid epidemic. Child psychiatrists have an important role to play in decreasing suffering through prevention, early intervention, treatment, family guidance, and support for people who have lost a family member or friend to OD.

Prevention

Prescription medications kept in the home are a substantial source of medication misuse and diversion. The majority of 12th graders with non medical use of narcotics in 2014 acquired them at no cost from a friend or relative (56%) or simply used their own prescription (35.1%).³ Providers working with children and adults can decrease youth access to prescription opioids for misuse by routinely discussing safe medication storage and disposal with all family members. A lock box is a secure way to store existing prescription

medication at home. Options for medication disposal include take back medication days sponsored by law enforcement and medication drop boxes managed by towns, pharmacies, or hospitals. If a medication take-back program is not accessible the Food and Drug Administration (FDA) provides guidelines on how to safely dispose of medication in the trash and a list of the limited number of medications that are recommended to be flushed down a sink or toilet. Providers should be educated about these options for medication disposal and might post these options in the office.

The risk for developing an opioid use disorder can be lessened by identification and treatment of child and adolescent onset psychiatric disorders that are associated with increased risk for substance use disorders (SUDs) such as attention deficit hyperactivity disorder and bipolar disorder. Routine and systematic screening for substance use is essential for prevention and early intervention. Standardized screening assessments are publically available and the CRAFFT is a commonly used screening tool for youth up to age 21 that assesses for alcohol, cannabis, and other drug use. When a young person is not using opioids or other substances they should receive positive reinforcement for making a healthy choice. Youth who are identified as high risk during screening should be evaluated further for a SUD and treated.

Treatment

Not all child psychiatrists will treat opioid use disorders but all should be familiar with recommended evidence based treatments to help refer youth to the appropriate provider and intervention. Evidence based therapies for SUDs appropriate for youth with an opioid use disorder include motivational enhancement therapy, the adolescent community reinforcement approach, cognitive behavioral therapy, and family based treatments. Although the evidence base is limited, medication assisted treatments such as extended release naltrexone, buprenorphine/naloxone, or methadone should also be considered for youth with an opioid use disorder. Extended release naltrexone is an opioid receptor antagonist with no restrictions around prescribing that can be used if a patient is sober from opioids. Buprenorphine/naloxone is a partial opioid agonist that can be prescribed in an outpatient setting by providers with a waiver ("X license") to stabilize a patient who is struggling to stop their opioid use. Buprenorphine/naloxone has been evaluated in two randomized controlled trials specifically with youth and is FDA approved for the treatment of youth 16 years of age. Methadone is a full opioid agonist that can only be prescribed for the treatment of an opioid use disorder in a methadone maintenance clinic. Methadone is less commonly used in youth but can be very effective in stabilizing treatment resistant cases with daily contact in a highly structured treatment program.

Youth with opioid use disorders often struggle early in their illness with limited insight and may be reluctant to engage in care or allow family involvement. Although issues with confidentiality are complicated it is important to obtain permission to communicate with families since their involvement is crucial. SUD treatment is generally voluntary, even when a young person is under the age of 18 years old, and it can be challenging for providers and family members to accept that a young person is not ready or willing to engage in care. Child psychiatrists and families can be effective in building a youth's motivation to engage

in care through contingency management. As an example, if a provider is prescribing medication or has a strong therapeutic alliance with a youth, they can consider making continued prescriptions and/or appointments contingent on follow up with a SUD evaluation and/or treatment. Child psychiatrists are experienced with providing family guidance and can work with family members to create contingencies in the home environment (e.g. making access to driving the car contingent on engagement in care and abstinence). One parent focused intervention that teaches behavioral and motivational strategies, the Community Reinforcement and Family Training, has promising early data supporting the efficacy of this approach to motivate youth to engage in care, decrease their substance use regardless of engagement in care, and improve the lives of parents by strengthening their self-care skills. By educating themselves on effective treatments for opioid use disorders child psychiatrists can be a valuable resource for families seeking support.

Many providers are uncomfortable discussing the risk for OD death associated with opioid use but families are best served by an explicit discussion. Regardless of a youth's readiness to engage in SUD treatment, providers should discuss risk factors for unintentional OD and encourage youth and family members to both obtain the prescription medication naloxone that can reverse an opioid OD. Naloxone is an opioid receptor antagonist that can be administered intranasally or injected intramuscularly to temporarily reverse an opioid OD. Naloxone has been a life saver for many as evidenced by the 26,463 documented drug OD reversals that resulted from the distribution naloxone kits to the general public through 109 organizations between 1996 and 2014.⁴

Supporting Family and Friends after an OD Death

When a young person dies of an OD, a child psychiatrist may be asked to support siblings, other family members, and friends through the bereavement process. The bereavement process after an OD death may be different than after a death from other causes. Although the literature is limited, the bereavement process after an OD death seems to be similar to death due to suicide and is more complicated than death due to other causes. Feigelman and colleagues compared measures of grief, psychological health, and stigma among 540 parents attending grief peer support groups who had lost children due to natural, accidental, suicide, or OD deaths.⁵ Compared to parents who lost their child to natural or accidental death those who lost their child due to suicide or OD death were more likely to have complicated grief, post-traumatic stress, depression, and psychological problems. Parents who lost their child due to suicide or OD death were also more likely to hear comments blaming the child and parent compared to parents who lost their child due to natural or accidental death. Feigelman and colleagues' work suggests that parents whose child died of an OD may need more support as they cope with this loss. Additionally, as every child psychiatrist recognizes, the death of one young person impacts a wide range of people in the community. Other people who may need informal support or formal treatment include: close friends, witnesses of the death (emergency responders), people with a history of similar sudden loss, systems within the community (a youth's school or workplace), and individuals with an opioid use disorder who may have known the deceased individual.

Literature on bereavement after a traumatic death has found it is important for survivors and family to find meaning from the person's life after their death. One possible way to find meaning is to recognize that their loved one suffered from an illness and to focus on remembering their child's healthy self. Parents of young adults often want to better understand their child's course in treatment as they try to understand the SUD illness that took their child's life. Parents may look to treatment providers to discuss details of their child's illness and treatment engagement. One challenge for providers who are supporting the survivors is that patient confidentiality through the Health Insurance Portability and Accountability Act (HIPAA) continues for a period of 50 years after the date of death of an individual. If a child age 18 or older did not sign a comprehensive release of information providers are limited in what they can disclose unless a family member formally becomes the legal executor of their child's estate by petitioning the court. Family members may or may not find it helpful to meet with providers who worked with their child after their death but it is important to offer this option as one way to provide support to families who may feel additionally isolated by stigma as they grieve. Parents with a similar loss may also be an important source of support. Compassionate Friends is a large national peer led organization that supports parents whose child has died regardless of the cause. Grief Recovery After Substance Passing, is a peer led organization specific to families whose loved one died due to substance use.

Next Steps

Every child psychiatrist needs to be well informed and ready to play their role in ending the senseless loss of young lives due to the opioid epidemic. Child psychiatrists can make a direct impact with prevention, early intervention, treatment, family guidance, and support for the community after loss of life. Additionally, child psychiatrists are needed to partner with other providers to address developmental differences between youth and adult onset opioid use disorders that impact engagement and retention in SUD treatment. To change the course of this epidemic in youth new models for SUD treatment such as imbedded care in the pediatric and school settings need to be evaluated. Furthermore, models of compulsory treatment for opioid use disorders in youth, similar to civil commitment for psychiatric illness, may have a role in keeping youth alive while providers work to increase their motivation to stop their opioid use.

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